



**Rate Setting for Non-State Providers:
Intermediate Care Facilities for Persons with Developmental Disabilities
Complete text**

Note: These emergency regulations represent the complete text of the permanently-adopted “final” regulations as amended by emergency/proposed amendments effective July 2, 2014. (The text in this document is also the text of the regulations in effect on July 1 as an emergency regulation.) The text of the permanently-adopted “final” regulations and emergency/proposed amendments are available on the OPWDD website at www.opwdd.ny.gov. Look under “Regulations & Guidance.”

Effective Date: Tuesday July 1, 2014

- **14 NYCRR is amended by the addition of a new Subpart 641-2 to read as follows:**

Subpart 641-2. Rates for Non-State Providers of Intermediate Care Facilities for Persons with Developmental Disabilities

641-2.1. Applicability. On and after July 1, 2014, rates of reimbursement for intermediate care facilities for persons with developmental disabilities (ICF/DD) services, other than those provided by OPWDD, shall be determined in accordance with this Subpart.

641-2.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

- (a) Allowable costs. Costs that are allowable under Subpart 635-6 or section 681.14(f) of this Title.
- (b) Base year. The consolidated fiscal report period from which the initial period rate will be calculated. Such period shall be January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis and July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis.
- (c) Base operating rate. Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.
- (d) Budget neutrality adjustment. Factor applied to adjust the proposed amount so that it is equivalent to the base amount of dollars.
- (e) Department of Health (DOH) Regions. Regions as defined by the New York State Department of Health (DOH), assigned to providers based upon the geographic location of the provider’s headquarters as reported on the consolidated fiscal report. Such regions are as follows:

- (1) Downstate: 5 boroughs of New York City, Nassau, Suffolk and Westchester;

Note: All new material.

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(2) Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;

(3) Upstate Metro: Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming;

(4) Upstate Non-Metro: Any counties not listed in paragraphs (1), (2) or (3) of this subdivision.

(f) Facility. The site or physical building where ICF/DD services are provided.

(g) Financing expenditures. Interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property.

(h) Individual. Person receiving ICF/DD services.

(i) ICF/DD. An intermediate care facility for persons with developmental disabilities, as such term is used in Part 681 of this Title.

(j) Initial period. July 1, 2014 through June 30, 2015.

(k) Lease/rental and ancillary payments. A provider's annual rental payments for real property and ancillary outlays associated with the property such as utilities and maintenance.

(l) Provider - an individual, corporation, partnership or other organization to which OPWDD has issued an operating certificate pursuant to Article 16 of the Mental Hygiene Law to operate an ICF/DD, and for which the NYS Department of Health has issued a Medicaid provider agreement.

(m) Rate sheet capacity. The certified capacity of the ICFs/DD operated by a provider.

(n) Reimbursable cost. The final allowable costs of the rate year after all audit and/or adjustments are made.

(o) Target rate. The final rate in effect at the end of the transition period for each provider.

641-2.3. Rates for providers of ICF/DD services.

(a) There shall be one provider-wide rate for each provider, except that rates for ICF/DD services provided to individuals identified as specialized populations by OPWDD shall be determined under section 641-2.9 of this Subpart. Adjustments may be made to the rate resulting from any final audit findings or reviews.

(b) Rates shall be computed on the basis of a full twelve month base year CFR, adjusted in accordance with the methodology as provided in this section. The rate shall include operating cost components,

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and capital cost components as identified in applicable subdivisions. Such base year may be updated periodically, as determined by DOH.

(c) Components of rates for ICF/DD services.

(1) The operating component shall be based on allowable costs identified in the consolidated fiscal reports. The operating component shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and ICF/DD, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services, and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, aggregated for all such providers in such region, such sum to be divided by base year salaried direct care dollars for each provider of a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider of a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care dollars of all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

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(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and agency administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars and contracted clinical dollars for the base year for each provider of a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits for the base year for each provider, divided by base year salaried direct care dollars of a provider, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for a provider. Such sum shall be divided by the base year salaried direct care dollars of such provider and such quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph

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(vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and agency administration allocation for the base year for a provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars and contracted clinical dollars for a provider) for the base year. The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Provider direct care hours, which shall mean the sum of base year salaried direct care hours and base year contracted direct care hours, such sum to be divided by the rate sheet capacities for the base year. Such quotient to be multiplied by rate sheet capacities for the initial period.

(xiv) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xv) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.

(xvi) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of a provider, divided by the rate sheet capacities for the base year, such quotient to be multiplied by the rate sheet capacities for the initial period for such provider.

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(xvii) Regional average contracted clinical hourly wage, which shall mean the quotient of contracted clinical dollars divided by the base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xviii) Provider contracted clinical hours, which shall mean the quotient of a provider's contracted clinical hours for the base year divided by the rate sheet capacities for the base year, such quotient to be multiplied by rate sheet capacities for the initial period.

(xix) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths.

(xx) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xv) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xiv) of this paragraph multiplied by twenty-five hundredths.

(xxi) Provider reimbursement from direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xiii) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xix) of this paragraph.

(xxii) Provider reimbursement from clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xvi) of this paragraph and the provider clinical hourly wage - adjusted for wage equalization factor, as determined pursuant to subparagraph (xx) of this paragraph.

(xxiii) Provider reimbursement from contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xviii) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xvii) of this paragraph.

(xxiv) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property the base year for a provider and such sum to be divided by provider rate sheet capacities for the base year. Such sum to be multiplied by rate sheet capacities for the initial period.

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(xxv) Provider operating revenue, which shall mean the sum of provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxii) of this paragraph, the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxiii) of this paragraph, and the provider facility reimbursement, as determined pursuant to subparagraph (xxiv) of this paragraph.

(xxvi) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of all provider rate sheets in effect on June 30, 2014, divided by provider operating revenue, as determined pursuant to subparagraph (xxv) of this paragraph, for all providers.

(xxvii) Total provider operating revenue-adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxv) of this paragraph and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvi) of this paragraph.

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, as determined by subparagraph (xxvii) of this paragraph, by the applicable provider rate sheet capacity for the initial period and such quotient to be further divided by three hundred sixty-five.

(2) Alternative operating component. For providers that did not submit a cost report or submitted a cost report that was incomplete for the base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision and the applicable regional average direct care hours, which shall mean the quotient of salaried and base year contracted direct care hours for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

(ii) the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xiv) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

(iii) the applicable regional average facility revenue, which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty,

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housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

Such sum shall then be multiplied by the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvii) of paragraph (1) of this subdivision.

(3) Day program services component. There shall be a day program services component for individuals who participate in either in-house day programming or day services, which shall equal the sum of the in-house day programming amount from the provider rate sheet in effect on June 30, 2014, plus the product of the units of service for the day services providers as was used in the calculation of the rate in effect on June 30, 2014 and the day service provider's rate in effect on July 1, 2014.

(4) Capital component.

(i) General principles. Capital costs shall be included in the rate at the lower of the amount determined pursuant to Subpart 635-6 of this Title or thresholds as determined pursuant to subparagraph (iv) of this paragraph. DOH may retroactively adjust the capital component.

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July 1, 2014.

(ii) Initial rate. The rate shall include the approved appraised costs of a lease or acquisition, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of such costs, continuing until such time as actual costs are submitted to OPWDD. The amount included in the rate shall not exceed the regional threshold rates for such period. Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to OPWDD within two years from the date of certification of estimated costs, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by OPWDD and supporting documentation of such costs shall be submitted to OPWDD, which shall transmit such information to DOH. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph. Capital costs may be amortized over a maximum fifteen year period for acquisition of properties or the life of the lease for leased sites, but in no circumstance shall the amortization exceed the length of the loan taken. Amortization shall begin upon certification

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by the provider of such costs. Start up costs may be amortized over a one year period beginning with certification. Limitations on reimbursement for such costs shall be the following:

- (a) Allowable acquisition, rehabilitation and new construction costs shall be determined in accordance with Subpart 635-6 of this Title. Acquisition costs are limited to the appraised value and acquisition and construction cannot exceed regionally based thresholds.
- (b) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.
- (c) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.
- (d) Design fees. Design fees may not exceed five percent above the fee schedule.
- (e) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate. Mortgages that do not amortize over the nominal mortgage term are not allowable.
- (f) Lease costs. Allowable lease costs shall be determined in accordance with Subpart 635-6 of this Title.
- (g) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs are not included.
- (h) Other costs. Maximum of \$20,000. Other costs may include but are not limited to legal and accounting fees.
- (i) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed \$10,000.
- (j) Purchase options. Limited to twelve months in length with a maximum of \$15,000 in cost.
- (k) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.

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(l) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works, security and bank site inspection.

(iv) Thresholds. Thresholds shall be determined pursuant to the following:

Residential rental sites

<i>Threshold for Residential Rental sites- leases less than 5-year term</i>				
Counties	certified capacity of 1	certified capacity of 2	certified capacity of 3	Each Increase in Certified Capacity by 1
Orange, Rockland, Putnam, Dutchess, Ulster	\$11,692	\$13,853	\$16,903	\$3,050
Nassau, Suffolk and Westchester Counties	\$15,251	\$18,809	\$22,495	\$3,686
New York City except Manhattan	\$21,351	\$24,909	\$28,468	\$3,558
Manhattan	\$28,341	\$32,153	\$35,585	\$3,431
All other Counties	\$9,023	\$10,548	\$12,200	\$1,652
<i>Heat Allowance For rentals which include Heat</i>	+ \$900	+ \$1,200	+ \$1,500	<i>4 or more + \$1,500 + \$300 additional</i>

<i>Threshold for leases greater than 5 years</i>	
New York City	\$13,217 per bed
Westchester, Nassau, Rockland and Suffolk Counties	\$10,548 per bed
Putnam, Orange, Dutchess and Ulster Counties	\$7,752 per bed
Upstate (all other counties)	\$5,465 per bed

Allowable renovation costs for new/relocating residential sites with leases less than 5- year term

<i>Renovation costs for residential leases less than 5 years</i>	
Counties	Threshold
New York City and the counties of Suffolk, Rockland Nassau, Westchester, Putnam, Orange, Dutchess and Ulster	Contract Costs for Renovation: The lesser of \$5,000 per bed, or \$25,000 per unit
	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost

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All other Counties	Contract Costs for Renovation: The lesser of \$3,000 per bed, or \$15,000 per unit
	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost

**Capital Thresholds for Residential Acquisitions- New or Relocation
(including Condominium and Cooperative Apartments)**

County	Capital Threshold Per Bed
Manhattan	\$228,161
Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$159,182
Putnam, Rockland, Suffolk	\$135,424
Columbia, Dutchess, Orange, Sullivan, Ulster	\$117,605
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$84,343
Upstate (all other)	\$77,622

Renovation costs in existing sites

County	Renovation Threshold - Existing Sites Cost per bed
Manhattan	\$ 114,081
Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$ 79,591
Putnam, Rockland, Suffolk	\$ 67,712
Columbia, Dutchess, Orange, Sullivan, Ulster	\$ 58,803
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$ 42,172
Upstate (all other)	\$ 38,811

Residential Start-Up Allowance

<i>Residential Start-up Allowance per bed</i>		
Counties	New	Relocations
New York City, Suffolk, Nassau, Westchester, Putnam, Rockland	\$5,800	\$1,000
Rest of the State	\$5,500	\$900

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Pre-Operational Rent Allowance

<i>Pre-operational rent allowance</i>		
	Without Renovations	With Renovations
Pre-operational rent allowance	1 month	3 months

Design Fees

Approved Construction Costs	Design Fee	
\$0 to \$15,000	\$3,000	Subject to OPWDD approval
\$15,001 to \$50,000	\$3,000	Plus 17.50% of cost over \$15,000
\$50,001 to \$100,000	\$9,125	Plus 15.50% of cost over \$50,000
\$100,001 to \$150,000	\$16,875	Plus 12.50% of cost over \$100,000
\$150,001 to \$200,000	\$23,125	Plus 10.00% of cost over \$150,000
\$200,001 to \$250,000	\$28,125	Plus 8.0% of cost over \$200,000
\$250,001 to \$300,000	\$32,125	Plus 4.75% of cost over \$250,000
\$300,001 to \$350,000	\$34,500	Plus 10.80% of cost over \$300,000
\$350,001 to \$400,000	\$39,900	Plus 10.60% of cost over \$350,000
\$400,001 to \$450,000	\$45,200	Plus 10.40% of cost over \$400,000
\$450,001 to \$500,000	\$50,400	Plus 10.20% of cost over \$450,000
\$500,001 to \$550,000	\$55,500	Plus 10% of cost over \$500,000
\$550,001 to \$600,000	\$60,500	Plus 9.80% of cost over \$550,000
\$600,001 to \$650,000	\$65,400	Plus 9.60% of cost over \$600,000
\$650,001 to \$700,000	\$70,200	Plus 9.40% of cost over \$650,000
\$700,001 to \$750,000	\$74,900	Plus 9.20% of cost over \$700,000
\$750,001 to \$1,000,000	\$79,500	Plus 10.20% of cost over \$750,000
\$1,000,001 to \$1,500,000	\$105,000	Plus 9.90% of cost over \$1,000,000
\$1,500,001 to \$2,000,000	\$154,500	Plus 9.90% of cost over \$1,500,000
\$2,000,001 to \$2,500,000	\$204,000	Plus 9.20% of cost over \$2,000,000
\$2,500,001 to \$3,000,000	\$250,000	Plus 7.60% of cost over \$2,500,000

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\$3,000,001 to \$3,500,000	\$288,000	Plus 7.50% of cost over \$3,000,000
\$3,500,001 to \$4,000,000	\$325,500	Plus 6.90% of cost over \$3,500,000
\$4,000,001 to \$4,500,000	\$360,000	Plus 6.30% of cost over \$4,000,000
\$4,500,001 to \$5,000,000	\$391,500	Plus 5.70% of cost over \$4,500,000
\$5,000,001 to \$5,500,000	\$420,000	Plus 5.10% of cost over \$5,000,000
\$5,500,001 to \$6,000,000	\$445,500	Plus 4.50% of cost over \$5,500,000
\$6,000,001 to \$7,000,000	\$468,000	Plus 5.70% of cost over \$6,000,000
\$7,000,001 to \$8,000,000	\$525,000	Plus 3.50% of cost over \$7,000,000
\$8,000,001 to \$9,000,000	\$566,000	Plus 2.50% of cost over \$8,000,000
\$9,000,001 to \$9,999,999	\$585,000	Plus 1.50% of cost over \$9,000,000

Soft costs

<i>Limited to the lesser of actual cost or threshold</i>
Site survey \$500 for existing site or \$5,000 (new construction)
Builders risk insurance \$2,000 for existing site, or \$4,000 (new construction)
Property casualty insurance \$2,000
Bank site inspection \$5,100 (new construction)
Performance Bond at 3% of the approved rehabilitation costs over \$99,999
Soil inspection at amount approved by OPWDD
Clerk of the works at amount approved by OPWDD
Security at amount approved by OPWDD

(a) Capital Review Thresholds for Residential Leased Space – Apartments (Lease term is less than 5 years) For apartment leases of five years or less, the thresholds are applied against the annual rent costs excluding any ancillary costs identified in the lease that are required to be paid to the landlord for services such as lawn care or maintenance. The average annual rent cost is calculated by multiplying the average monthly rent for the entire period of the lease by twelve. The annual property amount included in the rate is the lesser of their actual rental costs or the threshold rate, subject to the limitations in Subpart 635-6 of this Title. Actual ancillary lease costs that are required to be paid to the landlord for services shall be included in the rate.

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(b) Costs of residential acquisitions are included in the rate at the lesser of the provider's actual cost or the thresholds. The threshold includes the costs of building, land and rehabilitation costs (excluding contingency).

(c) For renovation costs in existing leased sites, allowable costs are limited to the lesser of the provider's actual costs or the threshold values listed. In addition, where approved by OPWDD, the provider is eligible for an additional allowance for contingency funds to address renovation cost overages with a limit of the lesser of actual cost overage or ten percent of the contract cost.

(v) Renovations of existing provider owned residential programs shall be funded through the Residential Reserve for Replacement (RRR).

641-2.4. Assessment. Rates shall include the assessment described in section 43.04 of the Mental Hygiene Law.

641-2.5. Reporting requirements.

(a) Providers shall report costs and maintain financial and statistical records in accordance with Subpart 635-4 of this Title.

(b) Generally Accepted Accounting Principles (GAAP). The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the provider unless the reporting instructions authorized specific variation in such principles. The State shall identify provider cost and providers shall submit cost data in accordance with generally accepted accounting principles (GAAP).

641-2.6. Trend Factor. For years in which DOH does not update the base year, subject to the approval of the Director of the Budget, DOH may use a compounded trend factor to bring base year costs forward to the appropriate rate period. The trend factor shall be taken from applicable years from consumer and producer price indices, including, but not limited to the Medical Care Services Index; U.S. city average, by expenditure category and commodity and service group for the period April to April of each year.

641-2.7. Transition to new methodology. The reimbursement methodology described in this subpart will be phased-in over a three-year period, with a year for purposes of the transition period meaning a twelve month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate as determined by the reimbursement methodology described in this subpart, according to the phase-in schedule outlined below. The base operating rate will remain fixed and the target rate, as determined by the reimbursement methodology in this subpart, will be updated to reflect rebasing of cost data, trend factors and/or other appropriate adjustments.

**Emergency Regulations: Rate Setting for Non-State Providers:
Intermediate Care Facilities for Persons with Developmental Disabilities
Effective: July 1, 2014**

Transition Year	Phase-in Percentage	
	Base operating rate	New Methodology
Year One (July 1, 2014 – June 30, 2015)	75%	25%
Year Two (July 1, 2015 – June 30, 2016)	50%	50%
Year Three (July 1, 2016 - June 30, 2017)	25%	75%
Year Four (July 1, 2017 – June 30, 2018)	0%	100%

641-2.8. Rate corrections

- (a) Arithmetic or calculation errors will be adjusted accordingly in instances that would result in an annual change of \$5,000 or more in a provider's annual reimbursement for ICFs/DD.
- (b) In order to request a rate correction in accordance with subdivision (a) of this section, the provider must send to Department of Health its request by certified mail, return receipt requested, within 90 days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

641-2.9. Specialized template populations. Notwithstanding any other provision of this Subpart, rates for individuals identified by OPWDD as qualifying for specialized template populations funding shall be as follows:

- (a) For individuals initially identified as qualifying for specialized template populations funding between November 1, 2011 and March 31, 2014

Residential – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$166,400
Upstate	\$150,500

**Emergency Regulations: Rate Setting for Non-State Providers:
Intermediate Care Facilities for Persons with Developmental Disabilities
Effective: July 1, 2014**

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$189,500
Upstate	\$171,500

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$136,500
Upstate	\$123,500

Day Services – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$41,730
Upstate	\$37,562

Day Services – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual-Operating only
Downstate	\$46,433
Upstate	\$43,063

(b) For individuals initially identified as qualifying for specialized template populations funding after March 31, 2014

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only

**Emergency Regulations: Rate Setting for Non-State Providers:
Intermediate Care Facilities for Persons with Developmental Disabilities
Effective: July 1, 2014**

Downstate	\$189,500
Upstate	\$171,500

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$136,500
Upstate	\$123,500

Day Services – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$46,433
Upstate	\$43,063

641-2.10. Severability. If any provision of this Subpart or its application to any person or circumstance is held to be invalid, the remainder of this Subpart and the application of that provision to other persons or circumstances will not be affected.